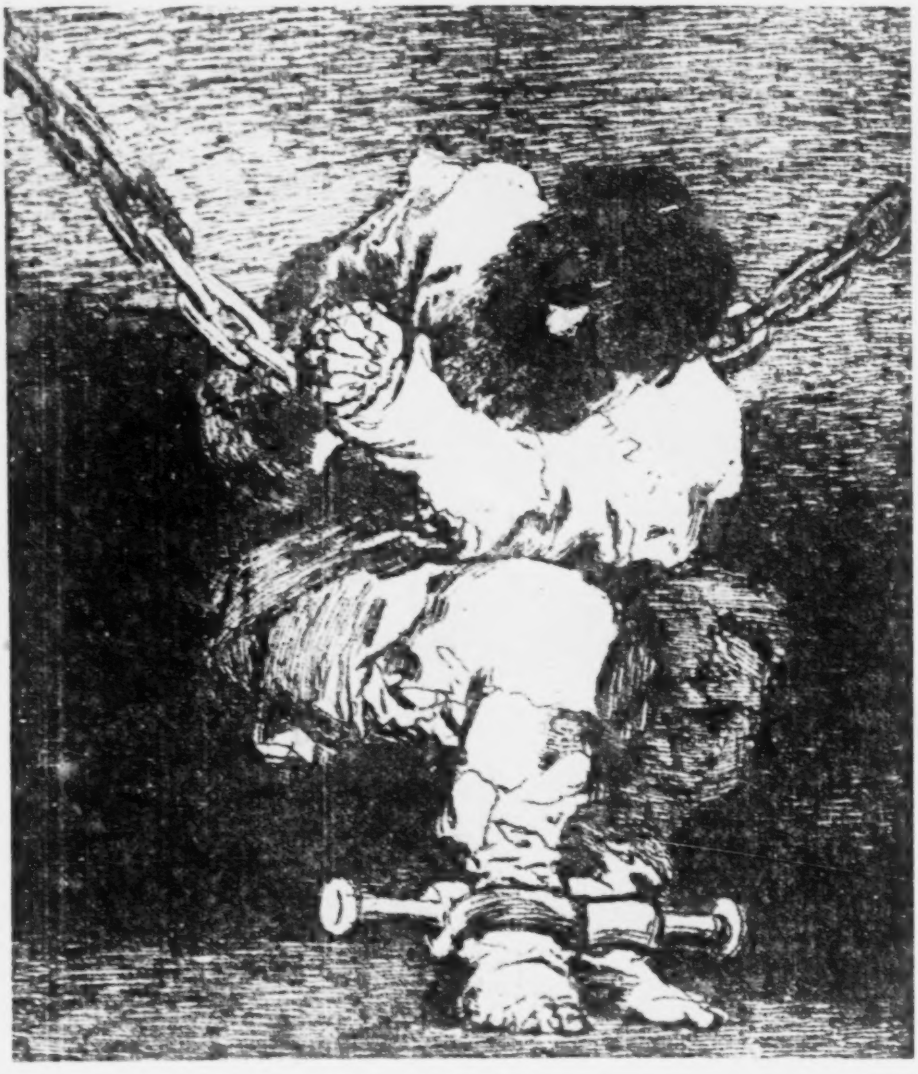
And Darkness Closes In...

NATIONAL STUDY OF JAIL SUICIDES



THE NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES
1337 22nd STREET, N.W., WASHINGTON, D.C. 20037

THE NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES
1337 22nd STREET, N.W., WASHINGTON, D.C. 20037 – 202/659-4156

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Robert L. Woodson
American Enterprise Institute
Washington, D.C.

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Points of view or opinions stated in this document are those of the National Center on Institutions and Alternatives, and do not necessarily represent the official position or policies of the U.S. Department of Justice.

FINAL REPORT TO THE NATIONAL INSTITUTE OF CORRECTIONS ON THE NATIONAL STUDY OF JAIL SUICIDES

THE NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES

314 North St. Asaph Street
Alexandria, Virginia 22314
703/684-0373

Lindsay M. Hayes
Project Director

Barbara Kajdan
Research Associate

October, 1981

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today
the pain of the clang of steel
reaches the depths of my soul
and i cry
tears of frustration...
and the new life i began
is dashed-shattered in pieces
of blue sky around my feet.
the dull puke-green bars and
yellow-white walls depress the spirit
and the sun doesn't shine for me
in this place of empty space
only darkness reigns
and the memory that i once found a friend
buried in the depths of a mental hospital...
but nothing much matters anymore
in an eight by eight by four foot cage
i am an animal in a cage
and the darkness is closing in...
help me, please...

Suicide Victim
August 13, 1981
County Jail, New Jersey

ACKNOWLEDGMENTS

A project of this scope was not completed solely by the efforts of the research team. I would like to express my gratitude to all those jail officials, state department of corrections administrators, and medical examiners for supplying essential data. Their courtesy and cooperation made this study possible.

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Lindsay M. Hayes
Project Director

EXECUTIVE SUMMARY

NCIA was able to document 419 suicides occurring in our nation's jails in 1979. This would mean that on any given day, at least one, and as many as two persons commit suicide in these facilities.

From data collected on 344 of the suicides identified in this study, a profile of the victim was constructed. An inmate committing suicide in jail was most likely to be a 22-year-old White, single male. He would have been arrested for public intoxication, the only offense leading to his arrest, and would thereby be under the influence of alcohol upon incarceration. Further, the victim would not have had a significant history of prior arrests. He would have been taken to an urban county jail and immediately placed in isolation for his own protection and/or surveillance. However, less than three hours after incarceration, the victim would be dead. He would have hanged himself with material from his bed (i.e., sheet or pillowcase). The incident would have taken place on a Saturday night in September, between the hours of midnight and 1:00 a.m. Jail staff would have found the victim, they say, within 15 minutes of the hanging. Later, jail records would indicate that the victim did not have a history of mental illness or previous suicide attempts.

The scenario described above is, of course, based solely on a "hypothetical construct" developed to call attention to those characteristics appearing most often in jail suicide victims.

Other significant findings concerned the suicide victim's most

serious charge and presence of alcohol and/or drugs upon arrest, the use of isolation, and the length of incarceration prior to the suicide.

In regard to the most serious charge, 73.6% of the suicide victims were charged with crimes which fell within the non-violent category. Alcohol/drug related charges accounted for over 30% of these charges.

In regard to the presence of intoxication upon arrest and confinement, almost 60% of the suicide victims were under the influence of alcohol and/or drugs at the time of incarceration.

Two out of every three inmates who committed suicide were being held in isolation.

Over 50% of the suicide victims were dead within the first 24 hours of incarceration, with 27% occurring within the first three hours. After a one month period, the percentage of suicides dropped considerably, from almost 80% to 20%.

This NCIA study also found significant relationships between intoxication, isolation, and length of incarceration. Over 88% of inmates under the influence of alcohol and/or drugs at the time of incarceration committed suicide within the first 48 hours of confinement, with over half of these victims being found dead within the first three hours of confinement.

In addition, the majority (63%) of the inmates placed in isolation committed suicide within the first 48 hours of incarceration, with over 30% of these victims dying within the first three hours of confinement.

The NCIA study offers several recommendations to jailers, public officials, and legislators on how they might prevent jail suicides in the future.

FOR JAILERS:

- Upon admitting inmates into your facility, be particularly alert for those who fall within the victim profile detailed above. Such inmates should be diverted from the jail to alternative services.

- Attention should be focused on the inmate during his/her initial period of incarceration, particularly during the first three hours.

- The use of isolation enhances the chance of a suicide, and it should, therefore, be prohibited. Inmates exhibiting suicidal behavior should be placed in the general population of the jail and/or kept under 24-hour "eye contact" supervision.

- Cosmetic precautions used to prevent suicides, e.g., barless windows and doors, tearaway blankets, and television monitors, should be considered superficial and in no way a substitute for much needed human interaction.

- The state of intoxication of a person upon incarceration greatly increases the likelihood of a suicide. The jailer who admits an intoxicated individual into his facility is inviting trouble.

FOR PUBLIC OFFICIALS AND LEGISLATORS:

- Increased use of pretrial release in localities and counties throughout the United States could dramatically reduce the number of jail suicides annually.

- Public intoxication and other alcohol related offenses should be decriminalized. Inebriated persons should be placed in alternative services. Where decriminalization of public intoxication has been adopted, the mandate should be more strongly enforced.

- Programs for the public inebriate should provide a wide range of support services following detoxification.

- Removing juveniles, public inebriates, and persons with mental illness and retardation from our nation's jails could significantly reduce the number of suicides in these facilities.

- States should establish, improve, and/or enforce systems for jail suicide reporting.

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I. SUICIDES IN JAIL: AN HISTORICAL REVIEW OF THE LITERATURE

According to Benjamin J. Malcolm (1975), former Commissioner of the City of New York Department of Corrections and current member of the U.S. Parole Board, "No other individual act in the prison setting carries such awesome impact as does suicide.... The very finality of the act obviates the aid we can give to victims of other tragedies." Today, there is growing concern among criminal justice personnel, public officials, and the lay public that this "awesome" act may be widespread and still increasing in frequency. This is especially true if the "prison settings" are restricted to county and municipal jails and lockups. According to Beigel and Russell (1973), "For the law enforcement officer in a jail setting, suicidal behavior is an omnipresent threat." Malcolm acknowledged that "the jail is called on to accomplish with limited resources that which many psychiatric hospitals with all their expert help cannot achieve - the prevention of suicide." The result is, as Christianson (1974) reported, that "county jails across the country have been reporting a drastic increase in suicides." For example, during a two-week period in 1980, fourteen suicides in county and local jails were identified solely by a review of a sample of local newspapers (Institutions, Etc., 1981).

Despite concern about the severity and incidence of suicide in jails, few large scale, comprehensive research projects have been conducted in this area. Christianson noted, "Even at this late date in American penology, however, very little substantial research has been

conducted to explain why so many - or so few - prisoners kill or mutilate themselves. As with other distasteful aspects of incarceration, the problem by and large continues to receive only cursory, post-mortem treatment." Beigel and Russell, reviewing the "Bibliography on Suicide and Suicide Prevention" of the National Institute of Mental Health, found that "the literature includes almost no articles on suicide attempts in prisons and none of attempts in jail." Austin and Unkovic (1977) characterized this topic as the victim of "relative neglect in criminology and corrections."

The collection of jail suicide data by government agencies is also lacking. The National Center for Health Statistics, the government's official body for recording deaths (including suicides), does not even have an informal category for institutionally related suicides, let alone jail suicides. The Federal Bureau of Prisons, keeping very informal records on jail suicides, reported only two suicides in jails during 1979. And, as will be shown later in this report, most state departments of correction have poor reporting systems for gathering even the more fundamental jail statistics. Perhaps the only nationwide data available on jail suicides come from the 1978 Census of Jails and Survey of Jail Inmates. This U.S. Department of Commerce report listed 611 deaths in jails during 1977, 297 of which were suicides. Unfortunately, the Survey was cursory, soliciting only information concerning the number of suicides and excluding temporary holding facilities that normally detain persons less than 48 hours.

Review of those few studies of jail suicides which have been conducted often raises as many questions as they answer. For example, one study of suicides in New York City jails (Malcolm, 1975) revealed that suicides were greater among non-addicts than addicts and greater among Whites than Hispanics. A second study, also focusing on New York City jails (Tracy, 1972), found that over half of the suicides were committed by known narcotic addicts and that a high percentage of suicides were committed by Americans of Puerto Rican descent.

Esparza (1973) reported a suicide rate of 57.5 per 100,000 inmates in his study of a sample of the county jails in a midwestern state. In contrast, Rieger (1971) reported a rate of 10.5 per 100,000 inmates in the federal prison population.

Findings of studies on jail suicide become even further disparate when the variable is criminal offense. Danto (1973) reported that six of the ten suicides he studied at the Wayne County, Michigan, Jail were committed by prisoners charged with a violent felony. Fawcett and Marrs (1973) discovered that 14 of the 21 inmates who committed suicide or who made "high intent suicide attempts" were charged with violent personal crimes, including nine murder charges. In contrast, Heilig (1973) found that of the 26 inmates who committed suicide in Los Angeles County facilities, none was charged with a violent personal crime. Martin's (1971) analysis of 13 suicides that occurred in New York City jails indicates that the vast majority of the victims were not charged with a violent crime.

One finding which has been seen consistently in these isolated

studies concerns the timing of suicides following incarceration. Malcolm noted that the "crisis period" occurs during an inmate's first three days in the jail. Tracy found one fourth of all prisoner suicides to occur within 24 hours of incarceration. Cooper (1976) indicated that "self-destruction generally takes place very shortly after arrest and confinement, sometimes within hours, but generally within the first week." Christianson, too, stated that "most suicides occur almost immediately after entry into jail."

Hudson and Butts (1978) also found suicides to occur within the initial period of incarceration, yet more interesting was their finding concerning the presence of alcohol. In their study of 70 jail and prison suicides occurring over a five-year period (1972-1976) in North Carolina, the researchers found that of the 34 victims taking their lives in the first 12 hours of incarceration, 85% were intoxicated at the time of death. Further, of the 40 victims committing suicide in the first 24 hours of confinement, 62% had been incarcerated on alcohol related charges. After a 24 hour period, the rates change dramatically. Hudson and Butts found that of the 30 victims committing suicide after 24 hours, only 7% were incarcerated on alcohol related charges.

While there have been studies of prison suicide, the generalization of these results to the jail is problematic. Beigel and Russell argued that "the findings of a study that focuses on suicidal behavior in prisons are not necessarily translatable to jails, where most inmates are awaiting trial rather than serving a sentence." Gibbs (1978a), studying over 300 inmates who had injured themselves while in New York

City jails and prisons concluded:

> Jails and prisons differ in the types of problems inmates face and in the nature and extent of emotional support required by those who are confined. The jail environment is a disorganizing and anxiety-provoking situation in which the support of the family can be a crucial coping resource. The prison environment is more of a dangerous world in which the maintenance of a manly image may be crucial for effective coping.

Yet, after an exhaustive review of the literature, Gibbs (1978b) admitted that "it appears that self-injury is a more serious problem in jail than in prisons or in the community. In those jails that contain both detention and sentenced prisoners, detention prisoners are more likely to injure themselves."

Closely related to this generalization issue are the findings of Flaherty's (1980) study of suicides by juveniles held in adult jails and juvenile detention centers. He found "support for our hypothesis that the rate of suicide among children held in adult jails and lockups is significantly higher than that among children in juvenile detention centers and children in the general population of the United States."

As these studies and reports indicate, and as Beigel and Russell emphasized, "The need for reliable data about suicidal behavior in jails is clear." Moreover, the need for these data transcends the mere compilation of statistics and isolated studies characterized by small sample sizes. These data are needed to effect the development of new strategies, programs, and jail reforms to significantly impact this problem.

II. NATIONAL STUDY OF JAIL SUICIDES

With the goals of compiling the first comprehensive, nationally-based statistics on jail suicides and using these data as the basis for well grounded program recommendations and training programs for jail personnel, the National Center on Institutions and Alternatives (NCIA) initiated its "National Study of Jail Suicides" in July, 1980. Under a one year grant from the National Institute of Corrections, U.S. Department of Justice, NCIA conducted a three-phase study on the problem of jail suicides. Phase I identified 16,909 jail facilities in the United States. Phase II surveyed those jails and identified 419 suicides occurring during 1979. Phase III gathered demographic data on 344 of these 419 suicides.

A) PHASE I - IDENTIFICATION OF JAILS

Jails are the criminal justice system's most abundant commodity, yet little seems to be known about them. Although research is now beginning to focus on jails, basic data are still unknown. How many jails are there? How many people are confined in them? These simple questions are still answered with, at best, "educated estimates."

According to the latest U.S. Department of Justice (1979) data, there were 158,394 people detained in 3,493 jails on any given day during 1978. However, this jail figure represents only those facilities which confine people for over 48 hours and, therefore, excludes all temporary holding facilities.

For purposes of the National Study of Jail Suicides, a jail was defined as any facility operated by a local jurisdiction (e.g., county, municipality, etc.), whose purpose is the confinement of inmates apprehended by law enforcement personnel. Jails, to the maximum extent possible, included temporary holding and pre-trial detention facilities, lockups, "drunk tanks," etc., which normally detain persons for less than 48 hours, and county facilities which normally detain persons for more than 48 hours.

The compilation of the jail listing, the National Directory of County and Local Jails, was hampered by the lack of existing data. Using a 1978 U.S. Department of Commerce listing of all law enforcement agencies throughout the country as a base, data were solicited from each state department of correction and planning agency. In many instances, states had limited data available and various definitions of "jails"; others had no data at all. In one case, a police department was found to be using a restraining chair (with straps and leg irons) as its jail.

This study eventually identified 16,909 facilities: 3,343 county jails and 13,566 local jails.[1] (The distribution of jails by state can be found in Appendix A.)

To the best of our knowledge, this Directory, which is published in

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[1]County jails are defined as commitment and pre-trial detention facilities (over 48 hours), and include such euphemisms as house of corrections, workhouse, correction center, and farm. Local jails are defined as temporary holding facilities (less than 48 hours) and include city jails and police department lockups.

a separate volume, is the most accurate accounting of the total number of jails in this country. Yet, it is by no means the final word. According to one state official, for example, an accurate count of the number of jails in his state is hampered by the fact that many small facilities "temporarily" close when the health inspector is scheduled to visit.

B) PHASE II - SURVEY OF JAILS FOR INCIDENCE OF SUICIDE

1. State Reporting Systems

After surveying the gathering of data in all facets of the criminal justice system, the President's Commission on Law Enforcement and the Administration of Justice (1967), concluded "...the United States is today, in an era of the high speed computer, trying to keep track of crime and criminals with a system that was less than adequate in the days of the horse and buggy."

This deficiency is nowhere more evident than in knowledge of our nation's jails. As reported earlier, locating the number of jails in our country is a difficult task. Harder still is placing a figure on the number of people who pass through these jails. According to Mattick (1968), "the best estimate of the number of jail commitments in the United States each year is at least one and a half million and may be as many as five and a half million."

Paramount to this is the difficulty in obtaining data on "sensitive issues." Requesting data on such concerns as jail populations, costs,

number of juveniles, assaults and deaths (including suicides) may be embarrassing to local jailers, as well as to individual states. Further, states and their localities do not always "share" data among themselves. In regard to data collection about jails at the state level, many states employ their departments of corrections, through an inspection division, to investigate and/or collect information on local jail incidents (i.e., deaths, disturbances, etc.).

During Phase II of this study, Project staff contacted each state department of corrections (DOC) for information concerning jail suicides occurring during calendar year 1979. That year was selected to allow the reporting of suicide information to coincide with other annual program reporting requirements of an agency. As can be seen in Table 1, only 20 state DOC's were found by our study to collect data on jail suicide. Further, only 128 suicides were reported to those DOC's during 1979, as opposed to the 226 suicides documented by NCIA to have taken place in those states.

TABLE 1

SUICIDE REPORTING SYSTEMS WITHIN
STATE DEPARTMENTS OF CORRECTION (DOC)

STATE	TOTAL REPORTED TO DOC	TOTAL REPORTED TO NCIA
CALIFORNIA	30	43
DISTRICT OF COLUMBIA	5	5
FLORIDA	18	21
HAWAII	5	5
ILLINOIS	13	15
KANSAS	1	1
MICHIGAN	17	22
MINNESOTA	4	5
MONTANA	6	6
NEW YORK[a]		27
NORTH CAROLINA	5	8
NORTH DAKOTA	2	2
OKLAHOMA	7	8
PENNSYLVANIA	7	16
SOUTH CAROLINA	4	8
SOUTH DAKOTA	3	4
VERMONT	1	1
VIRGINIA[b]		15
WASHINGTON[b]		8
WISCONSIN[b]		6
TOTAL	128	226

[a]The New York State Commission of Correction refused to release necessary information

[b]State reporting system established, yet data unavailable

There are various reasons for the discrepancy in reporting suicide, including the lack of a mandate on localities to do so, difference of opinion on where suicide occurs (i.e., jail or hospital), and supression of potentially embarrassing data.

Mandates on localities to report suicide data to the state are few

and far between. However, two exceptions stand out. The New York State Commission of Correction inspects and monitors the level of care provided for inmates in all facilities in the state, including municipal lockups, county jails, and state prisons. This "watch-dog" group's Medical Review Bureau not only documents deaths in the state's jails, but also conducts field investigations of deaths which occur under unusual circumstances.

The state of California seems to have the most comprehensive reporting system in the nation. According to state law, the Attorney General must be notified:

> In any case in which a person dies while in the custody of any law enforcement agency or while in custody in a local or state correctional facility in this State, such law enforcement agency or the agency in charge of such correctional facility shall report in writing to the Attorney General, within 10 days after the death, all facts in the possession of the law enforcement agency or agency in charge of the correctional facility concerning the death. Such writing shall be available for inspection by interested parties, except as to matters deemed privileged by the Attorney General.

In addition, local jailers in California must report suicides to the county coroner and the state Board of Corrections. Further, since July 1, 1979, jailers who detain juveniles for more than 24 hours must report the death of a youngster to the state Department of Youth Authority.

These reporting mechanisms resulted in the reporting of 30 out of 43 suicides identified in this study in the state of California during 1979. The remaining 13 suicides were derived from jail reports, medical examiner profiles, and newspaper clippings.

The reporting of a suicide is further complicated by officials who often differ as to the actual "location" of the suicide attempt and eventual death. Ronald K. Tauber, executive director of the Suicide Prevention of Alameda County, California, told Project staff that "The sheriff and the coroner come to different counts as to the actual number of jail suicides. The coroner records each suicide as having taken place at the location where the death occurs. This reporting procedure causes some jail suicides to be listed at the county hospital rather than at the jail." And, at the state level, a Pennsylvania Department of Health official told Project staff that, "A suicide attempt which takes place in a jail, but in which the individual dies on route to the hospital or at the hospital, would be classified in the appropriate hospital, not the jail."

Finally, the reporting of a jail suicide is hampered because not reporting such an incident could save a jailer considerable embarrassment. Suicides are sometimes placed in the "accidental" death category in an attempt to avoid public scandal and legal action. And, in regard to reporting such occurrences, one Colorado official told Project staff, "It is doubtful that precise and factual information now exists on suicide rates in all jails in the state. Reliance on questionnaires to accurately reflect the suicides cannot be depended upon because of potential legal liabilities by local officials."

2. Survey Instrument

During Phase II of this study, Project staff also developed a one-

page questionnaire and cover letter to be sent to jails in an effort to identify the extent and distribution of completed suicides during calendar year 1979. (A copy of this survey can be found in Appendix B.)

The 16,909 surveys were distributed by mail, along with a self-addressed, business reply envelope to assure a high-rate of return. As previously indicated, Project staff also contacted jail inspectors (within state departments of correction). Further, state attorney generals and medical examiners were contacted in order to obtain additional information and to validate existing data. Finally, a newspaper clipping service was utilized.

As can be seen in Table 2, out of 16,909 surveys mailed to jails in February, 1981, 157 suicides were reported by these facilities.[2] Data obtained from state departments of correction and medical examiners yielded an additional 90 suicides that had not been identified from other sources. Project staff were able to locate 78 more suicides not identified from other sources, through a newspaper clipping service. In addition, 94 suicides were identified through the combined efforts of the departments of correction, medical examiners, and the newspaper clipping service. The total number of jail suicides identified for 1979 was 419.

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[2]A total of 3,402 surveys were returned: 2,924 jails reported no suicides, 36 deaths (homicide, accident, undetermined causes) were reported, and 251 surveys were not identifiable. In addition, 157 suicides were reported by jails and 34 suicides were reported occurring in a year other than 1979.

TABLE 2

SOURCES OF JAIL SUICIDE IDENTIFICATION

RESPONSE FROM:	N	PERCENTAGE
JAILS	157	37.5
DEPARTMENTS OF CORRECTION AND MEDICAL EXAMINERS	90	21.5
NEWSPAPER CLIPPING SERVICE	78	18.6
COMBINATION OF ALL OF THE ABOVE	94	22.4
	419	100.0

As can be seen in Table 3, suicides identified in this study for 1979 were distributed in 48 states, plus the District of Columbia. California led all states with 43 suicides, followed by New York with 27. (As previously indicated, California and New York both have excellent "incident" reporting systems.) The suicides in six states (California, New York, Texas, Michigan, Ohio, and Florida) comprised 33% of all jail suicides in the country.

TABLE 3 - SUICIDES BY STATE

CALIFORNIA	43	DISTRICT OF COLUMBIA	5
NEW YORK	27	HAWAII	5
TEXAS	25	KENTUCKY	5
MICHIGAN	22	MINNESOTA	5
OHIO	22	NEW HAMPSHIRE	5
FLORIDA	21	WEST VIRGINIA	5
PENNSYLVANIA	16	COLORADO	4
MASSACHUSETTS	16	NEW MEXICO	4
ILLINOIS	15	SOUTH DAKOTA	4
VIRGINIA	15	TENNESSEE	4
GEORGIA	12	WYOMING	4
INDIANA	11	MISSISSIPPI	3
LOUISIANA	10	NEBRASKA	3
NEW JERSEY	10	DELAWARE	2
MISSOURI	9	NORTH DAKOTA	2
ALABAMA	8	RHODE ISLAND	2
NORTH CAROLINA	8	UTAH	2
OKLAHOMA	8	ALASKA	1
SOUTH CAROLINA	8	IDAHO	1
WASHINGTON	8	IOWA	1
ARKANSAS	6	KANSAS	1
MARYLAND	6	NEVADA	1
MONTANA	6	VERMONT	1
OREGON	6	ARIZONA	0
WISCONSIN	6	MAINE	0
CONNECTICUT	5		
		TOTAL	419

In conclusion, after an exhaustive search for existing data, Project staff identified 419 suicides in jails during 1979. However, because of the problems in suicide reporting, as discussed, care must be taken in considering this number of suicides the final one. The number could be, and probably is, greater.

C) PHASE III - GATHERING OF DEMOGRAPHIC DATA ON SUICIDES

During Phase III of this study, Project staff developed an in-depth, three-page questionnaire and cover letter aimed at identifying

characteristics of the suicide victim and suicide act. Information sought regarding the victim included race, sex, age, marital status, offense(s) for which inmate was being held, previous charges, and presence of alcohol and/or drugs at time of incarceration. In regard to the suicide act itself, information was sought concerning date and time of suicide, method, instrument used, time span between suicide and finding of victim, use of isolation, previous suicide attempts and/or indications of mental illness, and length of incarceration prior to suicide.

In addition, a facilities' characteristics form was developed to record data on location and type of facility, year of construction and last renovation, incidence of suicides in 1978 and 1980, and procedures of reporting requirements used during and after a suicide. (A copy of these materials can be found in Appendix C.)

These survey instruments were distributed by mail to those jails identified as having at least one suicide during 1979. This process was initiated in April, 1981. As can be seen in Table 4, the initial mailing resulted in 163 (39%) completed surveys being returned. A second mailing was done in June, 1981, resulting in an additional 77 (18%) completed surveys being returned. During a one-week period in July, 1981, jails who had not yet returned the survey forms were contacted by telephone. This process yielded 54 (13%) more surveys. Finally, data on 50 (12%) suicides were obtained from medical examiner reports and newspaper clippings. The total demographic data base became 344 suicides, or a 82% response/collection rate on 419 identified suicides in 1979.

TABLE 4

RESPONSES FROM SURVEY INSTRUMENTS

	N	PERCENTAGE
RESPONSES BY MAIL:		
FROM INITIAL MAILING	163	38.9
FROM SECOND MAILING	77	18.4
AFTER TELEPHONE CONTACT	54	12.9
OTHER SOURCES:		
DATA REPORTED BY MEDICAL EXAMINERS AND NEWSPAPER CLIPPINGS	50	11.9
NO RESPONSE:	75	17.9
	419	82.1

III. DEMOGRAPHIC FINDINGS AND DISCUSSION

A) PROFILE OF THE SUICIDE VICTIM

Victim data was obtained on 344 out of 419 suicides identified in this study. From these data, a profile of the victim was constructed. An inmate committing suicide in jail was most likely to be a 22 year old white, single male. He would have been arrested for public intoxication, the only offense leading to his incarceration, and would thereby be under the influence of alcohol. Further, the victim would not have had a significant history of prior arrests. He would be taken to an urban county jail and immediately placed in isolation for his own protection and/or surveillance. However, less than three hours after incarceration, the victim would be dead. He would have hanged himself with material from his bed (i.e., sheet or pillowcase). The incident would have taken place on a Saturday night in September, between the hours of midnight and 1:00 a.m. Jail staff would have found the victim, they say, within 15 minutes of the hanging. Later jail records would indicate that the victim did not have a history of mental illness or previous suicide attempts.

The scenario described above is, of course, based solely on a "hypothetical construct." Detailed findings of this study are presented below.

B) PERSONAL CHARACTERISTICS OF VICTIM

1. Race

As can be seen in Table 5, this study found that 67.3% of the

victims were White, 21.6% were Black, and 11.1% were designated "Other" (including Spanish/Mexican, American Indian, and Unspecified).

TABLE 5 - RACE

	N	PERCENTAGE
WHITE	231	67.3
BLACK	74	21.6
OTHER	38	11.1
TOTAL	343	100.0

UNKNOWN=1

These findings would seem to confirm previous studies indicating that Whites commit suicide in greater numbers than do Blacks. According to Hudson and Butts (1978), for example, 77% of the 70 suicide victims they studied were White. Heilig (1973) identified 88.5% of the 26 suicides he studied as White. Other studies give less importance to race as a factor in suicide. Danto (1973) found that only 40% of the 10 victims in the Wayne County, Michigan, Jail were White; Fawcett and Marrs (1973) found that 53.8% of the 13 suicides they studied in the Cook County, Illinois, Jail were White; and Martin (1971) found that 38.5% of the 13 suicides she studied in New York City facilities were White. However, studies reporting lower suicide rates for White victims originate in large urban areas where the Black inmate population is more prevalent. For example, Martin found that only 10% of the jail population of the New York City facilities were White.

2. Sex

As shown in Table 6, NCIA found that an overwhelming 96.5% of the

victims were male, while only 3.5% were female. This can most likely be attributed to the prepondance of males in our nation's jails.

TABLE 6 - SEX

	N	PERCENTAGE
MALE	332	96.5
FEMALE	12	3.5
TOTAL	344	100.0

3. Age

Past studies have shown that age is a significant factor in jail suicide. Danto found that 70% of the suicide victims were between the ages of 20 and 26, and Heilig found that 46.2% were between 20 and 29. Esparza found a mean of 28.6 years old, while Fawcett and Marrs found a mean of 33 years old.

As can be seen in Table 7, NCIA found that almost 75% of the victims in its study were 32 years old or younger, with 28.7% coming from the 18 to 22 year old category. Over 50% of the victims were between the ages of 18 and 27. The average age was 28. It should also be noted that 15 juvenile suicides (17 years or below) were recorded, comprising 4.5% of the suicide population.

TABLE 7 - AGE (IN YEARS)

	N	PERCENTAGE
17 AND BELOW	15	4.5
18 - 22	96	28.7
23 - 27	85	25.4
28 - 32	55	16.4
33 - 37	35	10.4
38 - 42	23	6.9
43 - 47	9	2.7
48 - 53	9	2.7
54 AND OVER	8	2.4
TOTAL	335	100.0

UNKNOWN = 9

4. Marital Status

As can be seen in Table 8, 53.5% of the victims were single, 9.4% divorced, and 1.0% widowed. An additional 5.9% were separated. Only 30% were married or living under a common-law relationship.

TABLE 8 - MARITAL STATUS

	N	PERCENTAGE
SINGLE	154	53.5
MARRIED	82	28.5
SEPARATED	17	5.9
DIVORCED	27	9.4
WIDOWED	3	1.0
COMMON-LAW	5	1.7
TOTAL	288	100.0

UNKNOWN=56

5. Most Serious Charge

Table 9 lists the victim's most serious and/or only charge at time of incarceration. As can be seen, 73.6% of the most serious offenses fall within the non-violent category. Alcohol/drug related charges account for over 30% of the most serious charges. Serious property offenses account for 22.2%; and the "minor other" category, including such items as petit larceny, traffic offenses, violation of probation, etc., comprise 21.1% of these offenses. In regard to the most serious offense being a violent crime, 26.4%, or only slightly more than one quarter, indicated the presence of violence.

TABLE 9 - MOST SERIOUS CHARGE

	N	PERCENTAGE
ALCOHOL/DRUG RELATED[3]	102	30.3
SERIOUS PROPERTY[4]	75	22.2
MINOR OTHER[5]	71	21.1
VIOLENT/PERSONAL[6]	89	26.4
TOTAL	337	100.0

UNKNOWN=7

Consistent findings regarding offense(s) committed, particularly those relating to violence, have not resulted from previous studies. Danto found that 60% of the victims had committed a violent felony, Esparza noted that 84% of the victims had a history of violence, and Fawcett and Marrs reported 61.5% violence among victims. One might hypothesize that these findings are due in part to the large urban areas

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[3]Offenses included in this category are public intoxication, driving while intoxicated, disorderly conduct, resisting arrest, possession of a controlled dangerous substance, distribution of a controlled dangerous substance, and narcotics (unspecified).

[4]Offenses included in this category are, burglary, grand larceny, auto theft, robbery (other), receiving stolen property, arson, breaking and entering, entering without breaking, vandalism, and carrying a concealed weapon and/or firearms.

[5]Offenses included in this category are shoplifting, petit larceny, prostitution, sex offenses (other), trespassing, unauthorized use of a motor vehicle, traffic offenses (other), violation of probation, contempt of court, vagrancy, indecent exposure, status offenses, escape, forgery, embezzlement, and other.

[6]Offenses included in this category are murder, negligent manslaughter, armed robbery, rape, indecent assault, assault, battery, aggravated assault, and kidnapping.

in which the studies were completed (i.e., Wayne County, Michigan, and Cook County, Illinois.) However, Heilig's findings from Los Angeles County and Martin's from New York City dispel this hypothesis. Heilig reported that victims in his study had committed no violent offense; in fact, 65.4% of the victims had been charged with drug and alcohol related offenses. Martin noted that 69.2% of the victims in her study were charged with property and drug offenses.

Despite the NCIA finding that only one quarter of the most serious offenses was violence related, a review of the literature uncovers data relating suicide to offenses in which a death occurred, particularly murder. This literature suggests that persons charged with various death-related offenses (i.e., 1st degree murder, manslaughter, attempted murder, etc.), are more likely to commit suicide than persons charged with other offenses.

The Federal Bureau of Prisons has warned local jailers that "persons held for murder or other offenses involving a possible death penalty" should be watched closely for any suicidal tendencies.

In addition to hypothesizing that an inmate prefers taking his own life rather than suffering through a long incarceration period and possible execution, theorists also argue that a suicide could be provoked by an inmate feeling particularly remorseful following the killing of a family member or acquaintance.

Although findings from the NCIA study do not support the view that offenses of jail suicide victims are "violence related," evidence from the present study does suggest that the offense of murder can be a

significant factor in an inmate's attempt to take his life. In this study, there were 35 murder related charges documented as being the most serious charge against the victim. This category was second only to public intoxication, for which 37 victims were incarcerated. Burglary was the most serious charge against 27 suicide victims, driving while intoxicated accounted for 25, and disorderly conduct, 24. These five offenses accounted for almost 44% of all victims in this study.

6. Additional Charges

Only 108 of the 337 victims (32%) for which data in this study was available had two charges, 33 (9.7%) had three charges, and 4 (1.1%) had four charges.[7] (The distribution of these charges can be found in Appendix D.)

7. Jail Status

As can be seen in Table 10, the overwhelming majority (91.4%) of suicide victims were on detention status at the time of their death.

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[7] It should be pointed out that Project staff recorded data on only the four most serious charges against the victim. However, very few victims had more than four charges against them.

TABLE 10 - JAIL STATUS

	N	PERCENTAGE
DETAINED	308	91.4
SENTENCED	29	8.6
TOTAL	337	100.0

UNKNOWN=7

8. Prior Charges

In regard to prior charges, data was obtained on 252 victims. Of these, 133 (52.7%) had one prior charge; 77 (31%) had two prior charges; and 47 (18.7%) had three charges.[8]

Further, out of the 133 cases with one prior charge, only 16 were violent offenses; of 77 cases with two prior charges, six were violent; and of 47 cases with three prior charges, eight were violent. Thus, out of a total of 257 prior charges, only 30, or 11.6% were violent in nature. (The distribution of these charges can be found in Appendix E.)

These findings strongly refute previous studies, particularly those of Danto and Esparza, which suggest that inmates with histories of violence are more prone to commit suicide than others. It would seem that suicide and presence of violence are not strongly related.

[8]It should be pointed out that Project staff recorded data on only the three most serious prior charges of the victim. However, only a small percentage of victims had more than three prior charges.

9. Intoxication (Drug and/or Alcohol)

Gordon C. Steinhauer, chairman of the board of the National Conference on Alcoholism, has stated (in the New York Times, 1980) that "about 60 percent of the people in county jails are in for alcohol-related offenses; out of that group, probably two-thirds would be diagnosed as alcoholics." According to New York State Commission of Correction figures for 1977, an estimated 43% of those committing suicide in jail were known to have a history of drug abuse.

The seriousness of this problem is magnified when it is linked to suicide. As already stated in this report, NCIA discovered that over 30% of the suicide victims had "alcohol/drug-related" charges as their most serious offense.

As can be seen in Table 11, almost 60% of the suicide victims in this study were under the influence of alcohol, drugs, or both at the time of incarceration. Alcohol accounted for almost 40% of this finding; drugs, 9.4%; and the presence of both alcohol and drugs, 11.3%.

TABLE 11 - INTOXICATION

	N	PERCENTAGE
ALCOHOL	82	38.5
DRUGS	20	9.4
BOTH	24	11.3
NEITHER	87	40.8
TOTAL	213	100.0

UNKNOWN=131

These findings correlate with previous studies of jail suicide. Hudson and Butts found that, of the 70 suicides in North Carolina's jails and prisons from 1972 to 1976, half occurred in the first 12 hours and 85% of those were intoxicated at the time. Since a vast majority of the victims were under the influence of alcohol at the time of death, the researchers stated that "'post-alcoholic depression', to which some have attributed this phenomenon, appears to be a poor explanation." Further, of the 40 inmates committing suicide in the first 24 hours, 62% had been charged on alcohol related offenses. Of the 30 inmates committing suicide after 24 hours, only 7% had been charged with alcohol related offenses.

C) CHARACTERISTICS OF THE SUICIDE ACT

1. Time

Previous studies have stated that the great majority of inmates commit suicide between midnight and 8:00 a.m., when staff supervision is at its lowest. As can be seen in Table 12, almost 50% of the suicides occurred during the nine hour period between 9:00 p.m. and 6:00 a.m. Midnight to 3:00 a.m. was the highest period for suicides with 65. Other peak hours were 3:00 a.m. to 6:00 a.m., (48); 6:00 to 9:00 a.m., (36); and 9:00 p.m. to 12:00 p.m., (49).

TABLE 12 - TIME

	N	PERCENTAGE
12 MIDNIGHT - 3:00 a.m.	65	20.0
3:00 a.m. - 6:00 a.m.	48	14.8
6:00 a.m. - 9:00 a.m.	36	11.1
9:00 a.m. - 12:00 p.m.	23	7.1
12:00 p.m. - 3:00 p.m.	23	7.1
3:00 p.m. - 6:00 p.m.	40	12.3
6:00 p.m. - 9:00 p.m.	41	12.6
9:00 p.m. - 12:00 p.m.	49	15.0
TOTAL	325	100.0

UNKNOWN=19

2. Date

As can be seen in Table 13, almost 50% of the suicides occurred on either a Thursday, Friday or Saturday, with Saturday having the most suicides, 57.

TABLE 13 - DAY OF WEEK

	N	PERCENTAGE
SUNDAY	50	14.7
MONDAY	46	13.6
TUESDAY	31	9.1
WEDNESDAY	48	14.2
THURSDAY	52	15.3
FRIDAY	55	16.2
SATURDAY	57	16.8
TOTAL	339	100.0

UNKNOWN=5

As can be seen in Table 14, more suicides occurred during the month of September than any other single month. Forty-two inmates took their lives during this month. The second greatest number of suicides occurred during June when 40 inmates took their lives.

TABLE 14 - MONTH

	N	PERCENTAGE
JANUARY	28	8.3
FEBRUARY	22	6.5
MARCH	33	9.7
APRIL	23	6.8
MAY	33	9.7
JUNE	40	11.8
JULY	28	8.3
AUGUST	26	7.7
SEPTEMBER	42	12.4
OCTOBER	24	7.1
NOVEMBER	21	6.2
DECEMBER	19	5.6
TOTAL	339	100.0

UNKNOWN=5

3. Method and Instrument

All previous studies are in agreement that hanging is the most prevalent method of jail suicide. As can be seen in Table 15, NCIA's data confirm this previous finding. An overwhelming majority of victims, 95.9%, chose hanging as their method of suicide.

TABLE 15 - METHOD

	N	PERCENTAGE
HANGING	329	95.9
OVERDOSE	5	1.5
CUTTING	1	0.3
SHOOTING	2	0.6
JUMPING	4	1.2
INGESTION	1	0.3
OTHER	1	0.3
TOTAL	343	100.0

UNKNOWN=1

In regard to the instrument used to commit suicide, Table 16 shows that 43% of the victims used their bedding. Over 30% used clothing other than shoelaces or belts.

TABLE 16 - INSTRUMENT

	N	PERCENTAGE
SHOELACE	11	3.3
BELT	28	8.5
OTHER CLOTHING	105	31.8
BEDDING	144	43.6
ROPE	1	0.3
RAZOR BLADE	1	0.3
GUN	2	0.6
TOWEL	16	4.8
DRUGS	5	1.5
OTHER (UNSPECIFIED)	17	5.2
TOTAL	340	100.0

UNKNOWN=4

The prevention of the suicide act is something that has continually haunted jailers. Various precautions are usually taken, including the

confiscation of sharp objects and clothing (i.e., belts) which could enhance the possibility of suicide. Jailers have also been known to renovate the jail cell in an effort to prevent suicides. Changes can include the installation of steel plates across the tops of cell bars; use of barless cell windows and doors; and the distribution of "tearaway" blankets. Television monitors are also now becoming popular in some jails. Yet, these cosmetic precautions for the most part have proved ineffective in preventing suicide. As Burtch and Ericson (1979) stated, "Recommendations for more vigorous cell searches to uncover dangerous weapons and improved screening methods to intercept potentially lethal contraband materials brought to inmates would, if implemented, probably have little effect upon the incidence of prisoners' suicide."

A common cry by jailers following a suicide is, "We did everything we could.... If someone really wants to kill themselves, they'll eventually find a way." Unfortunately, this excuse usually proves to be true. However, as argued later in this report (see Section V: Conclusions/Recommendations), attention should be directed not toward trying to outwit the potential suicide victim, but toward diverting the potential victim to much needed alternative services (e.g., detoxification, mental health counseling, etc.)

4. Time Span Between Suicide and Finding Victim

As can be seen in Table 17, over 35% of the respondents stated that they found the suicide victim in less than 15 minutes after the act.

However, 43.6% of the victims were not found until a 15 minute to one hour time-span had elapsed, with 26.8% not found until 30 minutes to 3 hours had gone by.

TABLE 17 - TIME SPAN

	N	PERCENTAGE
LESS THAN 15 MINUTES	112	36.4
15 - 30 MINUTES	94	27.3
30 - 60 MINUTES	56	16.3
1 - 3 HOURS	36	10.5
OVER 3 HOURS	10	2.9
TOTAL	308	100.0

UNKNOWN=36

5. Isolation

As can be seen in Table 18, two out of every three inmates (67.7%) identified in the NCIA study as committing suicide had been held in isolation.

TABLE 18 - ISOLATION

	N	PERCENTAGE
YES	228	67.7
NO	109	32.3
TOTAL	337	100.0

UNKNOWN=7

According to the regulations of one Pennsylvania county facility:

> Upon admission to the institution, each inmate is first processed and fingerprinted by the Correctional Officers. The receiving and screening process begins with immediate observation for suicidal tendencies. A two-part interview takes place. First, a medical report is filled out by the Correctional Officer noting background information and unusual behavior. After the inmate is through processing and showered, he is escorted to the medical department for his second interview, given by the medical department. Should the medic then conclude that the inmate does exhibit suicidal tendencies, the Correctional Officer proceeds to segregate the inmate from the general population and place him on around the clock 15 minute observation. Shortly thereafter, the inmate is seen by the doctor and psychiatrist for even further examination. (Emphasis added.)

In some facilities isolation is referred to as segregation, observation, padded cell, safety cell, suicide cell, restricted area, observation tank, drunk tank, or bullpen. It is simply, of course, isolation. Suicidal inmates are "red-tagged" in Lake County, Illinois, "physically restrained" in the District of Columbia, and "given the minimum necessities" in Medina County, Ohio.

The use of isolation in correctional facilities, jailers will say, is intended for inmates who are a danger to themselves and others. However, in the prevention of suicides, experts believe that isolation is counterproductive. In 1972, a lower court decision in New York limited the use of solitary confinement on the grounds that "human isolation might endanger the prisoner's sanity." Toch (1975) has written that inmates "react to solitary confinement with surges of panic, despair, or rage. They lose control, break down, regress." Burtch and Ericson concluded: "It appears that inmates in dissociation

and, to a lesser extent, in protective dissociation, commit suicide proportionately more than inmates situated in other areas." And Danto warned that depressed and/or suicidal inmates must not be kept in isolation.

It would appear that NCIA's findings, documenting that 67.7% of the victims had been placed in isolation, confirm previous theories linking the use of isolation with suicide.

6. Mental Health

Closely related to the use of isolation is the question of the victim's mental health prior to the suicide. Since over two-thirds of the victims had been placed in isolation, one might hypothesize that they were placed there for disciplinary reasons or because they had exhibited either a prior suicide attempt and/or some form of mental illness.

However as Table 19 indicates, when jailers were asked how many previous suicide attempts by the victims were known to jail officials, almost 83% said that none were known. As detailed in Table 20, when asked whether there was any indication of mental illness in the victim prior to his/her death, 70% of the jailers said they were not aware of any.

TABLE 19 - SUICIDE ATTEMPTS (KNOWN TO OFFICIALS)

	N	PERCENTAGE
YES	37	17.1
NO	180	82.9
TOTAL	217	100.0

UNKNOWN=127

TABLE 20 - MENTAL ILLNESS (KNOWN TO OFFICIALS)

	N	PERCENTAGE
YES	73	29.4
NO	175	70.6
TOTAL	248	100.0

UNKNOWN=96

These findings would seem to call into question the intended use of isolation and jailers apparent lack of knowledge of an inmate's mental health status. Thus, one might ask, "If an inmate's history of mental illness and/or suicide attempt(s) were not known to jail officials, why were those inmates placed in isolation?"

7. Length of Incarceration

In one of the most alarming findings of the NCIA study, Table 21 shows that over 50% of the victims were dead within the first 24 hours of incarceration, and an astounding 27% occurred within the first three hours. Contrary to previous studies which indicate that the "critical time" for suicide is less than three months, NCIA findings would suggest that the first 24 hours and up until one month are the most critical. After a one month period, the percentage of suicides drops considerably, from almost 80% to 20%.

TABLE 21 - LENGTH OF INCARCERATION

	N	PERCENTAGE
0-3 HOURS	87	27.0
4-6 HOURS	29	9.0
7-9 HOURS	12	3.7
10-12 HOURS	14	4.3
13-18 HOURS	9	2.8
19-24 HOURS	14	4.3
25-48 HOURS	21	6.5
3-14 DAYS	44	13.7
15-30 DAYS	27	8.4
2-4 MONTHS	41	12.7
5-7 MONTHS	16	4.9
8-12 MONTHS	5	1.6
MORE THAN 1 YEAR	3	.9
TOTAL	322	100.0

UNKNOWN=22

After being convicted for driving with a revoked license, Charles Nathan[9] began serving weekends in jail at a urban county facility in Wisconsin. On March 11, 1979, less than an hour after being placed in an administrative segregation cell, he was dead. On June 6, 1979, Tony Martin was arrested for "driving under the influence of alcohol" and placed in an urban Arkansas lockup. The time was midnight. Ten minutes later he was dead. On October 9, 1979, Bill Emerson was arrested for shiplifting and put in a rural South Dakota lockup. One hour later he was dead.

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[9]Names of victims used as illustrative examples throughout this report have been changed to ensure confidentiality. Facts of these cases are as they occurred.

On January 25, 1979, Jack Hart was arrested for armed robbery and violation of probation. He was taken to a rural county facility in Florida. Four months later he hanged himself. Larry Penrose was arrested on February 1, 1979, for the murder of his wife. He was taken to an urban county facility in California. Seven months later he was dead.

What these five different suicides point to is the interaction between the length of incarceration prior to suicide and the severity of the most serious charge. As can be seen in Table 22, 55.7% of all victims who were charged with alcohol/drug related offenses died within the first three hours of confinement. Further, of all the victims dying within the first three hours of incarceration, 62.8% were charged with alcohol/drug related offenses.

In contrast, almost 50% of all victims charged with violent/personal offenses died after 15 days of confinement, and usually between two and seven months. Only 8.5% of those offenders died within the first three hours.

TABLE 22 - LENGTH OF INCARCERATION BY MOST SERIOUS CHARGE

LENGTH	ALCOHOL/ DRUG RELATED	SERIOUS PROPERTY	MINOR OTHER	VIOLENT/ PERSONNAL	TOTAL
0-3 HOURS	54 (62.8/55.7)	12 (14.0/17.4)	13 (15.1/191.)	7 (8.1/8.5)	86 (100.0/27.2)
4-6 HOURS	15 (51.7/15.5)	2 (6.9/2.9)	6 (20.7/8.8)	6 (20.7/7.3)	29 (100.0/9.2)
7-9 HOURS	5 (41.7/5.2)	3 (25.0/4.3)	2 (16.7/2.9)	2 (16.7/2.4)	12 (100.0/3.8)
10-12 HOURS	0 (0.0/0.0)	5 (35.7/7.2)	3 (21.4/4.4)	6 (42.9/7.3)	14 (100.0/4.4)
13-18 HOURS	2 (25.0/2.1)	1 (12.5/1.4)	3 (37.5/4.4)	2 (25.0/2.4)	8 (100.0/2.5)
19-24 HOURS	5 (35.7/5.2)	2 (14.3/2.9)	5 (35.7/7.4)	2 (14.3/2.4)	14 (100.0/4.4)
25-48 HOURS	3 (14.3/3.1)	4 (19.0/5.8)	7 (33.3/10.3)	7 (33.3/8.5)	21 (100.0/6.6)
3-14 DAYS	6 (14.0/6.2)	13 (30.2/18.8)	14 (32.6/20.6)	10 (23.3/12.2)	43 (100.0/13.6)
15-30 DAYS	1 (2.9/1.0)	13 (38.2/18.8)	7 (20.6/10.3)	13 (38.2/15.9)	34 (100.0/10.8)
2-7 MONTHS	5 (10.2/5.2)	12 (24.5/17.4)	8 (16.3/11.8)	24 (49.0/29.4)	49 (100.0/15.5)
OVER 7 MONTHS	1 (16.7/1.0)	2 (33.3/2.9)	0 (0.0/0.0)	3 (33.3/3.7)	6 (100.0/2.0)
TOTAL	97 (30.7/100.0)	69 (21.8/100.0)	68 (21.5/100.0)	82 (25.9/100.0)	316 (100.0)

(Row%/Column%)

UNKNOWN=28

These NCIA findings are well supported in past literature which link suicide with the length of incarceration. The initial entry into a jail can be a frightening experience. For the first offender, the feeling is one of fear, confusion, and uncertainty of the immediate future. For the chronic offender, re-entry might engender frustration at finding oneself in a situation to which he vowed never to return.

Goffman (1961) alluded to the generally depressed mood of each offender entering the jail. Toch noted that the inmate's initial reaction to confinement may include disbelief followed by some sort of effort to gain release. The inmate then begins to worry about the length of confinement and the seriousness of the charges.

A feeling of confusion and alienation is manifested during the bureaucracy of intake. The new inmate is processed, like a carcass in a meat packing factory, from one room to the next. According to Gibbs (1978b), the scene in the jail's reception room is one of chaos, men shuffle and stumble in from police vans to await processing, while others loudly protest the legality of their incarceration. For the offender arrested for an alcohol related offense, the scene is characterized by withdrawal pains, sweating, shuddering, and vomiting. Such offenders are often suspected of being unclean and are commonly "deloused," a process which, according to Goldfarb (1975), is "utterly degrading and makes men begin to feel that they are no longer human beings."

In addition, the new inmate not only feels victimized by the system, but also helpless, ashamed, and alone. He must, however temporarily, deal with his "loses" -- family, friends, jobs -- all sources of support and stability. He also finds himself at a loss to control his present situation and his immediate future. In essence, the arrest has disrupted the individual's normal life. Irwin (1970) vividly described this disruption:

> These experiences -- arrests, trial, and conviction -- threaten the structure of his personal life in two

> separate ways. First, the disjoined experience of being suddenly extracted from a relatively orderly and familiar routine and cast into a completely unfamiliar and seemingly chaotic one where the ordering of events is completely out of his control has a shattering impact upon his personality structure. One's identity, one's personality system, one's coherent thinking about himself depend upon a relatively familiar, continuous, and predictable stream of events. In the Kafkaesque world of the booking room, the jail cell, the interrogation room, and the visiting room, the boundaries of the self collapse.
>
> While this collapse is occurring, the prisoner's network of social relations is being torn apart. The insulation between social worlds, and insulation necessary for the orderly maintenance of his social life, is punctured. Many persons learn about facets of his life that were previously unknown to them. Their 'business is in the streets.' Furthermore, a multitude of minor exigencies that must be met to maintain social relationships go unattended. Bills are not paid; friends are not befriended; families are not fed, consoled, advised, disciplined; businesses go unattended; obligations and duties cannot be fulfilled -- in other words, roles cannot be performed. unattended, the structure of the prisoner's social relations collapse.

It is not unusual for inmates subjected to this experience to respond with suicidal gestures. Several researchers have noted that inmates are likely to commit suicide during relatively early stages of their incarceration. Danto, and later, Esparza, found that inmates committed suicide within the first three months. Heilig, however, found that 19 of the 26 victims he studied took their lives within the first 24 hours of confinement. NCIA findings would support Heilig's research.

In summary, the NCIA study found that over 50% of the victims were dead within the first 24 hours of incarceration, and an astounding 27% occurred within the first three hours.

D) FACILITY CHARACTERISTICS

As previously reported, NCIA has documented 16,909 county and local jail facilities in the United States. There are 3,343 (19.8%) county facilities and 13,566 (80.2%) local facilities. However, as can be seen in Table 23, county facilities accounted for 70% of the suicides in this study.

TABLE 23 - TYPE OF FACILITY[10]

	N	PERCENTAGE
COUNTY	196	70.3
LOCAL	75	26.9
OTHER	8	2.9
TOTAL	279	100.0

UNKNOWN=65

In addition, NCIA discovered that 70.2% of all facilities were located in urban areas; 17.4% in suburban areas; and 12.4% in rural areas. Whites comprised 69.8% of the victims in urban jails; Blacks comprised 22.3%; "Other" (including Spanish/Mexicans, American Indians, and Unspecified) comprised 9.3%.

In regard to facility and most serious charge, NCIA found that almost 32% of the victims charged with violent/personal crimes committed

[10]County jails are defined as commitment and pretrial (over 48 hours) detention facilities. Local jails are defined as temporary holding facilities (less than 48 hours). "Other" is defined as state facilities which detain or commit individuals for less than one year.

suicide in county facilities, with 26.7% charged with serious property crimes. In contrast, local facilities accounted for almost 50% of the victims charged with alcohol/drug related crimes and 26.3% with "minor other" crimes.

IV. SPECIAL CONSIDERATIONS

A) JUVENILE SUICIDE

Each year over 479,000 juveniles are locked up in adult jails. According to a study by the Children's Defense Fund (1976), only 12% of these juveniles are held for serious crimes, with 66% committing property offenses. In addition, 18% are charged with status offenses (e.g., drinking, curfew violations, sexual promiscuity or running away), and 4% are jailed without having committed any offense.

Family conflict and emotional stress are among the reasons youth in the general population have a high suicide rate - 2.7 per 100,000 in 1978. A jail experience can bring on an additional crisis and significantly increase this suicide rate. In fact, Flaherty (1980) notes that juveniles held in adult jails commit suicide at approximately eight times the rate by children held in juvenile detention centers (12.3 per 100,000 versus 1.6 per 100,000), and four and a half times the rate by children in the general population (12.3 per 100,000 versus 2.7 per 100,000).

Flaherty studied 28 juveniles who committed suicide in 1978. Twenty-two of these suicides occurred in adult jails and lockups, six in juvenile detention centers. Half of the victims in jail had not committed a felony offense. To Flaherty, this is a finding "which implies that many of those juveniles who are imprisoned in jails pose little threat to their communities."

Flaherty also found that 17 of the 22 suicides taking place in adult facilities occurred in the context of "sight and sound separation" between adults and juveniles. The result could indicate that these young victims might have been subjected to less abuse from adult prisoners but more isolation without supervision during their confinement. A similar finding was reported by the Children's Defense Fund, who concluded: "Solitary confinement or confinement in a dark basement or closet-like enclosure for the sole child in an adult jail removes him from other inmates, but also from the attention of caretakers and can have severe traumatic effects on an already troubled and frightened youngster."

Danto has been a particularly vocal critic of the use of solitary confinement with juveniles. In Wooden's (1978) piercing investigation of incarcerated children, Danto notes:

> The leper role of a child placed in solitary confinement can only be viewed from the standpoint of sadistic management....In my opinion, if a child is placed in solitary confinement and commits suicide, we are dealing with homicide and this is placed on the staff, as they have left the child no other alternative by which he can assure himself of his humanness and individuality.... I think that mental health professionals must speak out against this heinous psychological crime which has been imposed upon the administratively exploited child.

Timothy Paxter, 16, was arrested on July 29, 1979, for public intoxication in urban Arkansas. Because the nearby county jail did not have adequate "sight and sound" separation for juveniles, young Timothy was transferred to a facility in another county and put in a cell designed for juveniles. He hanged himself that same day. The exact

time of death is unknown because the deputy made his rounds of the jail only four times during that night, and found Thomas only when he brought the youngster breakfast the next morning.

Bruce Thomas, 17, was arrested on February 15, 1979, on a second degree larceny charge, and held in lieu of a $250 bond. He was placed in a police headquarters cell in urban Connecticut. Five hours later he hanged himself with a belt. Jailers did not find him for between one and three hours after the hanging. Two police officers were temporarily suspended.

These two youngsters were not only victims of suicide, but of isolation. Of the 15 juvenile suicides documented in this study, 12 occurred in isolation, where they had been placed for their own protection. However, isolation was not their ally. NCIA found that only four juvenile victims were found in less than 15 minutes. Eight youths (57%) were found between 15 minutes and one hour, and two youngsters were found some time between one and three hours.[11] (It is interesting to note that 43.6% of the juveniles who committed suicide were found in 15 minutes to an hour, while only 27% of the adult victims took that long to discover.)

In other study findings on juvenile suicide victims, NCIA noted that the overwhelming majority of youths were White males. Eight victims were 17 years old, six were 16, and one was 15. In regard to the most serious charge, only five youngsters had been charged with a

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[11]The time span of finding one youth was unknown.

violent/personal or serious property offense. (Two youths were charged with murder, two with burglary and one with kidnapping.) Two juvenile victims had been charged with alcohol/drug related offenses. The majority (eight youngsters) were charged with "minor other" offenses, including two petit larcenies, two traffic offenses, two escapes, one carrying a concealed weapon, and one curfew violation.

Finally, in regard to length of incarceration prior to suicide, six (40%) of the youngsters died in less than 14 hours; five (33.3%) between 3 and 12 days; three (20.1%) between 25 and 35 days; and one (6.6%) after 10 months of confinement.

In conclusion, it can be seen from the above that little justification can be given to the jailing of juveniles, particularly the majority of whom are confined for relatively minor offenses. Jails and juveniles simply do not mix. These facilities have been found to present environmental and staffing limitations when confronted with juvenile intakes. If the physical and emotional well-being of a youngster is deemed important, his or her incarceration should be prohibited.

B) ISOLATION

> Tell her I appreciated her visit very much on Tuesday. It cheered me up to see her, but when she didn't come this weekend, I felt very sad. Tell her my head feels like it is in a vice. They are squeezing it from all angles. The pressure is unbearable. Tell her I wish her happiness and I said gondbye and not to forget me in her prayers.
>
> Suicide Victim
> September 5, 1979
> County Jail, Pennsylvania

> The means necessary to prevent suicide may amount to the deprivation of the rights of an individual. This deprivation when weighed against the need to prevent the inmate from taking his/her life or otherwise doing serious harm to himself or others is justified. Since, however, any restriction of the rights normally afforded inmates may give rise to lawsuit, the action taken must be reasonable under the circumstances and represent a good-faith judgement that the action taken was the least restrictive alternative available.
>
> RE: Segregation in an urban Missouri county jail.

The "least restrictive alternative" mentioned in the above passage is, of course, administrative segregation. In another jurisdiction it might be called solitary confinement, or the "hole." The list of different euphemisms is lengthy.

Isolation has many uses in jails. The "drunk tank" is used for the intoxicated individual during the withdrawal process. The "juvenile wing," as it is often referred to, is an isolation cell used to keep juveniles separate from adults both in "sight and sound." The "observation tank" might be used for those individuals expressing suicidal tendencies. A "padded cell" is used for the inmates diagnosed as being mentally ill. The "hole" is used for "problem" inmates.

In all instances, the use of isolation is for the convenience of the staff, and usually to the detriment of the inmate. Whether its use is disciplinary or observational, isolation can pose a special threat to inmates who have limited abilities to cope with frustration. The result is a cry for help, or as Toch relates, "Isolation Panic: A demand for the inmate's release from isolated confinement which he finds

fear-inspiring, intolerable, and obsessive. The prisoner dwells on the duration and/or circumstances of his situation, or his discomfort, and on his inability to engage in prison activities and social life."

The NCIA study found a strong relationship between isolation and the length of incarceration prior to suicide. As can be seen in Table 24, the majority, 63%, of inmates placed in isolation committed suicide within the first 48 hours of incarceration. Moreover, over 30% of these victims died within the first three hours of confinement. Of the victims committing suicide within the first three hours of incarceration, 77% had been placed in isolation. This finding further highlights the negative effects of isolation and gives overwhelming support for the theory that the use of such is strongly associated with suicide.

TABLE 24 - LENGTH OF INCARCERATION BY ISOLATION

LENGTH	ISOLATION YES	NO	TOTAL
0-3 HOURS	67 (77.0/30.6)	20 (23.0/20.0)	87 (100.0/27.3)
4-6 HOURS	20 (69.0/9.1)	9 (31.0/9.0)	29 (100.0/9.1)
7-9 HOURS	10 (83.3/4.6)	2 (16.7/2.0)	12 (100.0/3.8)
10-12 HOURS	11 (78.6/5.0)	3 (21.4/3.0)	14 (100.0/4.4)
13-18 HOURS	7 (77.8/3.2)	2 (22.2/2.0)	9 (100.0/2.8)
19-24 HOURS	9 (64.3/4.1)	5 (35.7/5.0)	14 (100.0/4.4)
25-48 HOURS	14 (66.7/6.4)	7 (33.3/7.0)	21 (100.0/6.6)
OVER 48 HOURS	81 (60.9/37.0)	52 (39.1/52.0)	133 (100.0/41.6)
TOTAL	219 (68.7/100.0)	100 (31.3/100.0)	319 (100.0)

(ROW %/COLUMN%)

UNKNOWN=25

Dan Williams, 33, was arrested for disorderly intoxication on March 25, 1979. He was brought to an urban county jail in Florida. A jail nurse interviewed him, and because he was deemed drunk and suicidal, Williams was placed in an administrative segregation cell. Two hours later he hanged himself with a belt.

Mary Alice Dupree, 16, was also a victim of isolation, yet hers started prior to her confinement. She was arrested in a rural New York community for several traffic offenses on November 23, 1979, and could

not pay $170 in fines. Twenty-five days later, after an apparent attempt to talk with someone on the outside by telephone, she hanged herself in a county jail lockup. She was found 30 to 60 minutes later.

Mary Alice's isolation is tied with her past. She had gone through six foster homes, a psychiatric hospital and two shelters for adolescents. She had also lived through two drug overdoses and a wrist-slashing. Her family did not try to contact her in jail, pay the fines, or get her out of confinement. She was said to have kept to herself, either by choice or involuntary circumstances.

Here was a young girl whose past had been a form of solitary confinement. Her arrest and subsequent incarceration only manifested her "emotional" isolation from the world. And, in response to the criticism of her jailing (following the death), the judge, a part-time town justice, stated, "This was a traffic case. Where else do you expect me to put someone."

Beyond the presence of emotional solitary confinement is the physical isolation of the jail environment. Stephen Short experienced such isolation. Arrested for breaking and entering in a suburban Massachusetts community on March 12, 1979, Short hanged himself with a shoelace five hours later. He had been brought to his police department cell at 1:30 a.m. According to other prisoners in the cell block, Short began to tie his shoelaces to the bars soon after his arrival. An initial attempt at hanging failed, stated a fellow inmate, and Short had to try a second time. In the meantime, inmates in sight of the suicide attempt yelled and banged the cell walls with their hands and feet. But

their calls went unanswered because the cell block was at the opposite end of the corridor from the police department's operations room. During that hour of the night, most officers were on patrol or in the operations room. Some officers acknowledged later that it was difficult to hear noises from the cell block. Short's body was found a half hour later while an officer was making his routine check of the confinement area.

An inquest was held to determine if the suicide could have been prevented. It was later stated that the suicide could not have been stopped because Stephen Short was in a "self-destructive state of mind." Factors contributing to that mental state, according to the inquest, included a history of suicide attempts; anger over severed relationships with a girlfriend, sister and police; fear of having no place to live, no one to protect him; fear of being rearrested again; and degree of intoxication upon arrest.

Should Stephen Short have been placed in isolation in a jail? To borrow from the previously stated regulation in an urban Missouri county facility: "The action taken must be reasonable under the circumstances and represent a good-faith judgment that the action was the least restrictive alternative available."

C) INTOXICATION (DRUG AND/OR ALCOHOL)

According to the National Association of Counties (1980), although only three to five percent of the 10 million problem drinkers in the United States are chronic public inebriates, they comprise a group which

experiences repeated contacts with the police. Further, it is estimated that 40% of all arrests made each year are for public drunkenness, disorderly conduct, drunk driving, and other alcohol-related offenses. Many of these individuals are repeat offenders. In most communities they are still put in jail because police have nowhere else to put them. And, most jails are not able to provide the supportive environment, medical attention, and in general, helping atmosphere so critical to the care of alcoholics during withdrawal. During withdrawal the public inebriate is in extreme pain, frightened, cold, and highly prone to such endangering events as seizures, liver failure, and delirium tremens (DT's).

"After doing time in a lock-up, an alcoholic is on the edge of withdrawal," stated Timothy Flynn, a staff attorney at the Center for Law in the Public Interest in California. In a recent issue of the magazine, Alcoholism (1981), he noted, "The drunk is in pain. If he pleads 'not guilty' he will be kept 30 days awaiting trial. He knows that means 30 days of agony."

If there is a hearing, it is often a ritual Flynn calls "assembly line justice." The judge usually dismisses the case because the inebriate has already served his time. If, on the other hand, he pleads guilty, Flynn continued, "he knows the police will let him out in three days. When he gets back on the street his fear of this excruciating pain drives him to drink. The police come round and pick him up again."

Efforts have been initiated recently to decriminalize public intoxication, and thus divert the inebriate to alternative services,

such as detoxification centers, community living facilities, and after care services. Currently, over 30 states have decriminalized public intoxication, yet inebriates continue to be incarcerated, often for other alcoholic-related charges. Thus, although arrests for public intoxication have decreased, inebriates continue to be jailed in great numbers.

There are various reasons for the continued incarceration of such persons. One has been alluded to earlier - the lack of alternative services. However, even if these services were in great supply, many groups, principally law enforcement officials, believe that jail is a necessary backup.

The Los Angeles Police Department, for example, opposes all efforts to decriminalize public intoxication. According to police officials quoted in Alcoholism magazine, "The arrest capability alone serves as a motivator for inebriates who are reluctant to seek treatment; and is a vital alternative for protecting those who refuse diversion."

Thus, in the same vein that jailers argue for the use of isolation, police officials justify the arrest of a public inebrate for "his own protection."

Dr. Joseph A. Pursch, medical director of the Comprehensive Care Corporation, goes one step further. As spokesman for the profit-making alcohol treatment center conglomerate, Pursch told the magazine:

> Every drunk driver should be jailed immediately upon arrest, and should be held for a minimum of 48 hours. No bail, no bargaining, no release. It's important that the jail time be immediate, not 30 days down the road, when it will lose a lot of effect. Immediate

> jail time can be very therapeutic, based on my understanding that behavior changes will most likely take place when the person is in crisis and when the adversive experience is new and foreign to his or her lifestyle. It is also safe, because people who are caught drunk driving are, by definition, drunk and driving. It seems a shame to fingerprint them and go through the arrest process and then release them when they are still physiologically out of it.

Findings from the NCIA study would greatly challenge Dr. Pursch's assertions. NCIA found a very strong relationship between intoxication and length of incarceration prior to suicide. As can be seen in Table 25, an overwhelming majority, 88.9%, of inmates under the influence of alcohol and/or drugs at the time of arrest committed suicide within the first 48 hours of confinement. In addition, over 50% of these victims died within the first three hours of confinement. This latter finding confirms the research of Hudson and Butts who found that "post-alcoholic depression" was a poor explanation for the "sudden" suicide of inmates under the influence of alcohol. It would appear that the "alcoholic state" of the individual, and not the depression following withdrawal, contributes greatly to a suicide.

TABLE 25 - LENGTH OF INCARCERATION BY INTOXICATION

LENGTH	INTOXICATION YES	NO	TOTAL
0-3 HOURS	60 (93.8/51.3)	4 (6.3/4.7)	64 (100.0/31.7)
4-6 HOURS	21 (84.0/17.9)	4 (16.0/4.7)	25 (100.0/2.4)
7-9 HOURS	6 (60.0/5.1)	4 (40.0/4.7)	10 (100.0/5.0)
10-12 HOURS	3 (33.3/2.6)	6 (66.7/7.1)	9 (100.0/4.5)
13-18 HOURS	3 (42.9/2.6)	4 (57.1/4.7)	7 (100.0/3.5)
19-24 HOURS	5 (62.5/4.3)	3 (37.5/3.5)	8 (100.0/4.0)
25-48 HOURS	6 (40.0/5.1)	9 (60.0/10.6)	15 (100.0/7.4)
OVER 48 HOURS	13 (20.3/11.1)	51 (79.7/60.0)	64 (100.0/31.5)
TOTAL	117 (57.9/100.0)	85 (42.1/100.0)	252 (100.0)

(Row%/Column%)

UNKNOWN=92

NCIA's findings further showed that 93.8% of the victims committing suicide within the first three hours of incarceration had been under the influence of drugs and/or alcohol at time of arrest.

Finally, Table 25 indicates that of those victims not intoxicated at time of arrest, 60% committed suicide after the first 48 hours of confinement.

Two examples from this study illustrate the findings. Barry Merritt, 27, was arrested on June 6, 1979, for driving while intoxicated. He was brought to a suburban Massachusetts police station

at midnight. One hour later he was found hanging by his shirt from the bars of his cell. Three months later on September 2, 1979, Walt Rosen, 49, was also arrested for disorderly conduct and public intoxication. He was taken to a police station lockup in California and placed in a cell. Less than two hours later, Rosen was found hanging from the bars of his cell by a telephone cord.

In regard to the relationship between type of facility and intoxication, Table 26 indicates that 57.8% of the victims found in county facilities were not under the influence of alcohol and/or drugs at time of incarceration. In contract, almost 95% of the victims found in local facilities were under the influence of alcohol and/or drugs.

TABLE 26 - TYPE OF FACILITY BY INTOXICATION

	INTOXICATION		
TYPE	YES	NO	TOTAL
COUNTY	54 (42.2/50.5)	74 (57.8/94.9)	128 (100.0/69.2)
LOCAL	50 (94.3/46.7)	3 (5.7/3.8)	53 (100.0/28.6)
OTHER	3 (75.0/2.8)	1 (25.0/1.3)	4 (100.0/2.2)
TOTAL	107 (57.8/100.0)	78 (42.2/100.0)	185 (100.0)

(Row%/Column%)

UNKNOWN=159

V. CONCLUSIONS/RECOMMENDATIONS

Data presented within this report clearly documents the significant number of suicides plaguing our nation's jails. On any given day, at least one, and as many as two persons commit suicide in these facilities. NCIA hopes that these findings will lead to actions directed toward reducing the high incidence of suicide in our jails.

From data collected on 344 suicides identified in this study, a profile of the victim was constructed. An inmate committing suicide in jail was most likely to be a 22-year-old White, single male. He would have been arrested for public intoxication, the only offense leading to his arrest, and would thereby be under the influence of alcohol upon incarceration. Further, the victim would not have had a significant history of prior arrests. He would have been taken to an urban county jail and immediately placed in isolation for his own protection and/or surveillance. However, less than three hours after incarceration, the victim would be dead. He would have hanged himself with material from his bed (i.e., sheet or pillowcase). The incident would have taken place on a Saturday night in September, between the hours of midnight and 1:00 a.m. Jail staff would have found the victim, they say, within 15 minutes of the hanging. Later, jail records would indicate that the victim did not have a history of mental illness or previous suicide attempts.

The scenario described above is, of course, based solely on a "hypothetical construct" developed to call attention to those

characteristics appearing most often in jail suicide victims. Further, according to Ronald K. Tauber, Suicide Prevention for Alameda County, California, "In an effort to reduce the suicide rates in jails, it is important to focus on booking procedures, staff training, obtaining new prisoners' mental health histories, the decision whether to place in a single or multiple cell, observation, and transfer to a mental health unit." With these points in mind, NCIA would like to offer the following recommendations to jailers, public officials, and legislators, respectively, on how they might prevent future suicide occurrences in the future.

A) FOR JAILERS

RECOMMENDATION 1: *Upon admitting offenders into your facility, be particularly alert for those who fall within the victim profile detailed above. Such inmates should be diverted from the jail to alternative services.*

There are certain warning signals identified in the literature which may be helpful in identifying the potential suicide victim. The New York State Sheriff's Association Institute (1981) lists the following physical symptoms of a suicidal inmate:

- Sadness and crying;
- Withdrawal, silence;
- Loss or gain in appetite marked by weight gain or loss;
- Insomnia, awakening early and not being able to return to sleep;
- Mood variations; and
- Lethargy - slowness of physical movements; such as walking and talking.

In addition, Danto (1981) suggests several other warning signs which are tied to the inmate's recent past:

- o History of mental illness prior to incarceration;
- o History of previous suicide attempt or joking about ending it all;
- o History of belligerent or combative behavior upon admission, particularly caused by drinking;
- o Absence of family support through visits by relatives or letters from them;
- o Recent death of loved one or divorce; and
- o History of suicide in the family.

RECOMMENDATION 2: *Attention should be focused on the inmate during his/her initial period of incarceration, particularly during the first three hours.*

As highlighted in this study, over 50% of the suicide victims were dead within the first 24 hours of incarceration, with 27% occurring within the first three hours. After a one month period, the percentage of suicides dropped considerably, from almost 80% to 20%.

RECOMMENDATION 3: *The use of isolation enhances the chance of a suicide, and it should, therefore, be prohibited. Inmates exhibiting suicidal behavior should be placed in the general population of the jail and/or kept under 24 hour "eye contact" supervision.*

The use of isolation, jailers will say, is intended for inmates who are a danger to themselves and others. However, in the prevention of suicides, isolation is counterproductive. Whether its use is disciplinary or observational, isolation can pose a special threat to inmates who have limited abilities to cope with frustration. In addition, the use of isolation can initiate and swell depression in an

inmate. As indicated in this study, two of every three inmates (67.7%) who committed suicide were being held in isolation. In addition, the majority (63%) of inmates placed in isolation committed suicide within the first 48 hours of incarceration, with over 30% of these victims dying within the first three hours of confinement.

RECOMMENDATION 4: *Cosmetic precautions used to prevent suicides, e.g., barless windows and doors, tearaway blankets, and television monitors, should be considered superficial and in no way a substitute for much needed human interaction.*

Barry Levin, 25, was arrested for driving while intoxicated on November 30, 1979. He was taken to a suburban Massachusetts police station and placed in a cell at 11:20 p.m. He was last heard from at 12:35 a.m. when he asked for, and was denied, a cigarette over the intercom system used in the cell block. (The intercom system was a device used to monitor potential suicidal inmates.) At 1:05 a.m., Levin was found hanging by his shirt from the bars of his cell.

The precautionary "tools" used to prevent suicide are insufficient. For example, isolation and intercom systems are more often designed for the convenience of jail personnel, and not for the benefit of the inmate. Indeed, their use may heighten the depersonalizing aspects of confinement - the inmate having to "relate" to a disembodied TV monitor or loudspeaker.

If an inmate cannot be diverted from the jail facility, attention should be directed, not toward outwitting him, but to lending assistance and support.

According to the New York Sheriff's Association Institute:

> One of the most important reasons for an officer to be attentive to the emotional needs of an inmate is that the inmate may not be suicidal yet. The inmate could be desperately searching for a reason to live and seeking help. Denial on the part of the officer of the individual's problem and withdrawal or lack of attention, or human kindness could literally cause this individual to decide to kill him/herself, and to confirm the inmate's feelings that his/her life is not worth living and that death is the only answer to his/her problems.
>
> You will not endanger an inmate's life by discussing their suicidal thoughts; on the contrary you will acknowledge the suicidal thoughts and encourage verbalization which is desired. Don't be judgmental, always assume a suicidal threat or attempt is of a serious nature. All cries for help are genuine and cannot be measured by the apparent seriousness of the threat.

RECOMMENDATION 5: *The state of intoxication of a person upon incarceration greatly increases the likelihood of a suicide. The jailer who admits an intoxicated individual into his facility is inviting trouble.*

As indicated in this study, over 30% of the suicide victims had been incarcerated on alcohol/drug related charges. In addition, almost 60% of all suicide victims were under the influence of alcohol, drugs, or both, at the time of incarceration.

NCIA found that the overwhelming majority (88.9%) of inmates under the influence of alcohol and/or drugs at the time of incarceration committed suicide within the first 48 hours of confinement, with half these victims being found dead within the first three hours of confinement.

As with individuals exhibiting other suicidal tendencies, persons

under the influence of alcohol and/or drugs should not be placed in isolation. The time immediately following the arrest of an intoxicated person is critical since withdrawal symptoms are often evidenced. During this period the individual may be in extreme pain, frightened, cold and highly prone to such endangering events as seizures, liver failure, and delirium tremens (DT's). Such an individual does not belong in jail, and should be treated in a detoxification center, or if unavailable, a hospital emergency room.

B) FOR PUBLIC OFFICIALS AND LEGISLATORS

RECOMMENDATION 6: *Increased use of pretrial release in localities and counties throughout the United States could dramatically reduce the number of jail suicides annually.*

Thus far, pretrial release programs are scarce and in their infancy. Jails without such programs are at a strong disadvantage in regard to suicide prevention.

Take, for example, an urban city jail in Ohio. George Franklin, 20, was arrested on February 15, 1979, on two minor traffic warrants. He was jailed after failing to post a $215 bond. He hanged himself one day later. Two weeks later, Charles McPherson, 27, was arrested by the same police for "investigation of auto theft charges." He was taken to the jail and hanged himself a half hour later. Police officials later admitted that McPherson's wife told them he had been despondent for some time and had cut his wrists in an aborted suicide attempt a few weeks earlier.

In an urban Michigan police station, three inmates committed suicide within three months of each other. All died within the first two hours of incarceration. They had been arrested for public intoxication, trespassing, and driving under the influence of alcohol, respectively.

In a rural Louisiana town jail, Patricia Jessie, 40, was arrested on June 19, 1979, for resisting arrest and disturbing the peace. Police considered her to be mentally retarded, under the influence of alcohol and drugs, and exhibiting suicidal tendencies. She hanged herself 30 minutes after jailers isolated her in a cell.

The suicides described above might have been prevented if those jails had pretrial release programs.

In jails where pretrial release is used, results are impressive. In Tucson, Arizona, the Pima County Jail has seen a 90% decrease in suicide attempts and completed suicides over the past several years since implementing a pretrial release program. Offenders are rated according to their residence, family ties, employment and prior criminal record. Those having a total of five points on the scale are good candidates for immediate release. The use of bail is not even considered. In addition, use of the program has spawned decreases in failure-to-appear and rearrest rates. Finally, 35,000 fewer jail days were served last year because of the program.

RECOMMENDATION 7: *Public intoxication and other alcohol related offenses should be decriminalized. Inebriated persons should be placed in alternative services. Where decriminalization of public intoxication has been adopted, the mandate should be more strongly enforced.*

Currently over 30 states have decriminalized public intoxication, and the number of public inebriates entering jail has declined. However, no state has completely eliminated arrests for public intoxication. Inebriates continue to be arrested on other alcohol related charges, such as disorderly conduct or disturbing the peace. (In the NCIA study, disorderly conduct was the fifth most frequent charge, following public intoxication, murder, burglary, and driving while intoxicated.)

According to a National Association of Counties (1980) survey of county alcoholism services, 60% of the counties reported taking the public inebriate to a detoxification center or hospital emergency room following arrest. However, 76% also reported they may first detain the inebriate in jail, a "drunk tank," or alcoholism unit within the jail.

RECOMMENDATION 8: *Programs for the public inebriate should provide a wide range of support services following detoxification.*

A continuum of care is needed for the public inebriate. Several organizations, such as the National Association of Counties and National Coalition on Jail Reform, believe that this care should include:

- Rescue squads where volunteers or medical personnel pick up public inebriates, determine the treatment needed, and transport them to the proper facility.

- o Detoxification centers where services include medical care, counseling, living quarters, and out-patient therapy.
- o Dormitory shelter care where homeless people receive a bed, food, and clean clothing, perhaps also counseling and medical care.
- o Community living facilities where those who have successfully completed other programs can stay while making a gradual re-entry into the community.
- o Aftercare services where those who have completed detoxification programs receive counseling services, group therapy, family therapy, or perhaps referral to Alcoholics Anonymous.

RECOMMENDATION 9: *Removing juveniles, public inebriates, and persons with mental illness and retardation from our nation's jails could significantly reduce the number of suicides in these facilities.*

As previously indicated, over 479,000 children are locked up in adult jails each year. The suicide rate is approximately four and a half times the rate by children in the general population. Each year there are more than one million arrests for public drunkenness. Persons arrested for alcohol related offenses comprised over 30% of the NCIA documented jail suicides. Estimates on the number of mentally ill and mentally retarded individuals in jail each year are as high as 600,000. Often they are held for such minor offenses as loitering, vagrancy, and disturbing the peace.

For the most part, these groups end up in jail because communities have not developed alternatives to meet their needs. In jail their problems go unsolved, and the risk of suicide increases significantly. They should be removed from such facilities.

RECOMMENDATION 10: *States should establish, improve, and/or enforce systems for jail suicide reporting.*

The current state systems used for suicide reporting are haphazard and often lack any legislative mandate. States and localities have always had a "guarded" relationship, with the sharing of information, particularly that of sensitive data (i.e., suicides) being limited. These states would do well to follow the impetus of California and New York, both of which established, by law, excellent jail inspection units and reporting systems.

The National Study of Jail Suicides has investigated a serious problem plaguing our nation's jails. While we now know more about jail suicide than we did in the past, additional research is warranted. The act of committing suicide occurs as a result of many factors. Future research could include: investigation of the jail environment in which the suicide occurred; in-depth examination of the victim's autopsy report and medical records; and performance of a psychological autopsy in which the goal is to reconstruct the victim's psychological condition prior to committing suicide. Such research could provide insight into many still unanswered questions.

VI. APPENDICES

APPENDIX A
NATIONAL DIRECTORY OF COUNTY AND LOCAL JAILS

Forward

Jails are the criminal justice system's most abundant commodity, yet little seems to be known about them. Although research is now beginning to be directed toward our jails, basic data are still unknown. How many jails are there? How many people are confined in them? These simple questions are still answered with, at best, "educated estimates."

According to the latest National Prisoner Statistics data, there were 158,394 people detained in 3,493 jails on any given day during 1978. However, this jail figure represents only those facilities which confine people for over 48 hours, and, therefore, excludes all temporary holding facilities.

The National Institute of Corrections requested the National Center on Institutions and Alternatives (NCIA) to conduct a national study of jail suicides. Underlying this project was the task of identifying all county and local jails throughout the United States, including temporary holding facilities.

For purposes of this study, a jail was defined as any facility operated by a local jurisdiction (e.g. county, municipality, etc.), whose purpose is the confinement of inmates apprehended by law enforcement personnel. Jails, to the maximum extent possible, included temporary holding and pre-trial detention facilities, lockups, "drunk tanks," etc., which normally detain persons for less than 48 hours, and county facilities which normally detain persons for more than 48 hours.

NCIA has identified 16,909 facilities and has compiled them in this Directory. We believe this to be the most comprehensive Directory of jails published to this point.

The compilation of this listing was difficult - to say the least. Using the 1978 Bureau of the Census Jail List as a base, data were solicited from each state department of corrections and planning agency. In many instances, states had limited data available and various definitions of "jails"; others had no data at all. In one case, a police department was found to be using a restraining chair (with straps and leg irons) as its jail.

To the best of our knowledge, this Directory is an accurate portrayal of the number of jails in this country. Yet, it is by no means the final word. According to one state official, an accurate count of the number of jails in his state is hampered by the fact that many small facilities "temporarily" close when the health inspector is scheduled to visit.

In addition to the Bureau of the Census, the department of corrections and planning agencies in each state, thanks goes to the American Correctional Association and staff at the Community Research Forum for their help. Special thanks go to Barbara Kajdan and Leonard Berman, members of the NCIA Project. Finally, Project staff are indebted to Allen Breed, Director of the National Institute of Corrections, and Phyllis Modley and Marie Mactavish, Project Monitors, for their help and support.

Lindsay M. Hayes
Project Director
National Center on
Institutions and Alternatives

May, 1981

TABLE I

TYPE OF FACILITY

STATE	COUNTY	LOCAL	TOTAL
Alabama	69	284	353
Alaska	--	72	72
Arizona	38	71	109
Arkansas	76	169	245
California	127	395	522
Colorado	63	188	251
Connecticut	6	111	117
Delaware	5	35	40
District of Columbia	--	11	11
Florida	95	296	391
Georgia	199	413	612
Hawaii	4	4	8
Idaho	44	107	151
Illinois	99	807	906
Indiana	91	311	402
Iowa	100	311	411
Kansas	103	238	341
Kentucky	117	234	351
Louisiana	66	261	327
Maine	16	126	142
Maryland	36	113	149
Massachusetts	17	348	365
Michigan	87	581	668
Minnesota	87	356	443
Mississippi	89	182	271
Missouri	117	561	678
Montana	57	71	128
Nebraska	93	172	265
Nevada	21	16	37
New Hampshire	14	205	219
New Jersey	27	497	524

TABLE I (Cont.)

STATE	COUNTY	LOCAL	TOTAL
New Mexico	32	69	101
New York	63	633	696
North Carolina	106	329	435
North Dakota	53	102	155
Ohio	93	817	910
Oklahoma	77	346	423
Oregon	39	161	200
Pennsylvania	73	1,050	1,123
Rhode Island	--	37	37
South Carolina	71	190	261
South Dakota	66	111	177
Tennessee	104	200	304
Texas	255	765	1,020
Utah	30	129	159
Vermont	16	72	88
Virginia	107	177	284
Washington	43	223	266
West Virginia	55	150	205
Wisconsin	74	388	462
Wyoming	23	71	94
U.S. TOTALS	3,343	13,566	16,909

APPENDIX B

NATIONAL STUDY OF JAIL SUICIDES

INFORMATION REQUESTED BY:

THE NATIONAL CENTER ON
INSTITUTIONS AND ALTERNATIVES
ON BEHALF OF THE
NATIONAL INSTITUTE OF CORRECTIONS
U.S. BUREAU OF PRISONS
U.S. DEPARTMENT OF JUSTICE

FROM THE DIRECTOR
NATIONAL INSTITUTE OF CORRECTIONS

The National Institute of Corrections has requested the National Center on Institutions and Alternatives (NCIA) to conduct a national study of jail suicides. NCIA will utilize these data to generate programmatic recommendations to confront this issue. This information can then be employed by the National Institute of Corrections to implement technical assistance to jail personnel toward prevention of future jail suicides.

DATA PROVIDED BY INDIVIDUAL JAILS WILL BE CODED AND HELD IN THE STRICTEST CONFIDENCE. RESULTS OF THIS STUDY WILL BE PRESENTED IN SUMMARY FASHION, THUS PREVENTING THE DIRECT LINKAGE OF SPECIFIC DATA TO THE PARTICULAR JAIL FROM WHICH THE INFORMATION ORIGINATED.

Data requested for this study should be limited to suicides occurring between January 1, 1979, and December 31, 1979. These dates were selected to allow your reporting of this information to coincide with your other annual program reporting requirements.

In order to facilitate data compilation, we request that you utilize the definitions provided on the back of this form. When this is not possible, please inform us of specific differences in your reporting.

For your convenience in submitting the completed form, we have enclosed a self-addressed, business reply envelope. We request that the completed form be returned within thirty (30) days of its receipt.

If you have any questions regarding completion of this form or the study, please contact Mr. Lindsay Hayes of NCIA at (202) 659-4158. Thank you for your cooperation. Copies of the final report will be available upon request.

Sincerely,

Allen F. Breed

ALLEN F. BREED
Director
National Institute of Corrections
Washington, D.C.

PLEASE TURN OVER

DEFINITIONS

SUICIDE: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any self-inflicted act perpetrated by that individual. (NOTE: Attempts at suicide not resulting in death are excluded.)

HOMICIDE: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any non-self-inflicted act perpetrated against that individual by a second party.

ACCIDENT: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any non-intentional, identifiable act.

UNDETERMINED CAUSES: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any unknown or unspecifiable act or agent.

JAIL: Any facility, operated by a local jurisdiction (e.g. county, municipality, etc.), whose purpose is the confinement of inmates apprehended by law enforcement personnel. Jails, as defined here, will, to the maximum extent possible, include temporary holding and pre-trial detention facilities, lock-ups, "drunk tanks," etc., which normally detain persons for less than 48 hours,and county facilities which normally detain persons for more than 48 hours.

NATIONAL: All 50 states plus the District of Columbia.

INMATE: Any individual in the physical custody of any law enforcement agency.

In the spaces provided below, please indicate the TOTAL NUMBER OF INMATE DEATHS IN EACH CATEGORY occurring at your facility BETWEEN JANUARY 1, 1979, AND DECEMBER 31, 1979. Please do not leave any spaces blank. If information is unavailable, please indicate "UN"; if zero, please indicate "0." Please note any reporting differences on Item 3 of the form.

Please call Mr. Lindsay Hayes at 202/659-4158 if further clarification is needed.

— — — — — — — — — — — — — — — — — — —

QUESTIONS

1. Number of inmate deaths between January 1, 1979, and December 31, 1979, by:
   (a) Suicide _____
   (b) Homicide _____
   (c) Accident _____
   (d) Undetermined Causes _____

2. Which of the following categories best describes your facility? (Please check all that apply.)
   (a) Facility for committed/sentenced offenders _____
   (b) Temporary holding facility for 0 to 4 hours _____ or 4 to 48 hours _____
   (c) Pre-Trial detention facility (over 48 hours) _____
   (d) Other (Please specify) _____

3. Additional remarks (e.g. differences in definitions and/or reporting practices; attach additional sheets if necessary).

The following will be used for internal purposes only:

4. Completed by (name/title):
5. Name of facility:
6. Address (street):
   (City, State, Zip Code):
   (County):
7. Telephone:
8. Date completed:

Please return to: NCIA, Room 1024, Dupont Circle Bldg., 1346 Connecticut Ave., N.W.
Washington, D.C. 20036

APPENDIX C
NATIONAL STUDY OF JAIL SUICIDES

PHASE II

SURVEY QUESTIONNAIRE

THE NATIONAL CENTER ON
INSTITUTIONS AND ALTERNATIVES
ON BEHALF OF THE
NATIONAL INSTITUTE OF CORRECTIONS
U.S. BUREAU OF PRISONS
U.S. DEPARTMENT OF JUSTICE

Items contained in this questionnaire refer to suicides occurring at your facility in 1979 as identified during Phase I of this National Study of Jail Suicides. As appropriate in each question, please check the appropriate box(es) and/or fill in the blanks. PLEASE USE A SEPARATE QUESTIONNAIRE FOR EACH VICTIM. Thank you for your cooperation.

(Please Print)

NAME OF FACILITY _____

PART A: PERSONAL CHARACTERISTICS OF VICTIM

Please supply the following demographic information on each suicide victim.

1) Victim's name (or any other identifiable notation):

_____
Last First Middle

2) Race/Ethnicity:
(1) ____ White
(2) ____ Black
(3) ____ Spanish Heritage/ Chicano/Mexican American/Etc.
(4) ____ American Indian
(5) ____ Other (Please Specify) _____
(9) ____ Unknown

3) Sex:
(1) ____ Male
(2) ____ Female

4) Age: ____ Years

5) Marital Status:
(1) ____ Single
(2) ____ Married
(3) ____ Separated
(4) ____ Divorced
(5) ____ Widowed
(6) ____ Common-Law Relationship
(9) ____ Unknown

6) Please specify charge(s) for which victim was incarcerated at time of suicide and whether victim was being detained or had been sentenced.

CHARGE(S)	DETAINED	SENTENCED
_____	(1) ____	(2) ____
_____	(1) ____	(2) ____
_____	(1) ____	(2) ____

7) If known, please specify previous charge(s) against victim.

CHARGE(S)	DATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

8) At the time of incarceration, was the victim under the influence of:

(1) _____ Drugs Only
(2) _____ Alcohol Only
(3) _____ Drugs and Alcohol
(4) _____ Neither Drugs or Alcohol
(9) _____ Unknown

PART B: SUICIDE CHARACTERISTICS

1) What was the date and time of victim's death?

Date: / /79 Time: a.m. p.m.

2) What was the method of suicide and instrument used?

a) Method

(1) _____ Hanging
(2) _____ Overdose
(3) _____ Cutting
(4) _____ Shooting
(5) _____ Jumping
(6) _____ Ingestion of Foreign Object(s)
(7) _____ Other (Please Specify) _____
(9) Unknown

b) Instrument

(01) _____ Shoelace
(02) _____ Belt
(03) _____ Other Clothing
(04) _____ Bedding
(05) _____ Rope
(06) _____ Razor Blade
(07) _____ Gun
(08) _____ Towel
(09) _____ Knife
(10) _____ Glass
(11) _____ Drugs (Specify) _____
(12) _____ Other (specify) _____
(99) _____ Unknown

3) What was the time span between suicide and finding of the victim?

(1) _____ Less Than 15 Minutes
(2) _____ Between 15 and 30 Minutes
(3) _____ Between 30 and 60 Minutes
(4) _____ Between 1 and 3 Hours
(5) _____ Greater Than 3 Hours
(9) _____ Unknown

4) Was the victim isolated from other inmates at the time of his/her death?

(1) _____ Yes If "Yes," explain the type of isolation _____
(2) _____ No
(9) _____ Unknown

5) Were there any known previous suicide attempts by the victim?

(1) _____ Yes If "Yes," how many? _____
(2) _____ No
(9) _____ Unknown

6) Were there any indications of mental illness in the victim prior to his/her suicide?

(1) _____ Yes If "Yes," explain these indications and method(s) by which they were identified. _____

_____

(2) _____ No
(9) _____ Unknown

7) What was the total number of hours, days, months, or years that the individual had been held in your facility prior to his/her death? (If less than two days, indicate in hours.)

_____ Hours
_____ Days
_____ Months
_____ Years
_____ Unknown

8) What was the maximum inmate capacity of your facility at the time of the inmate's suicide? _____

9) What was the inmate population at the time of the inmate's suicide? _____

Survey completed by (Name/Title): _____

_____

Date completed: _____

Please check if you would like a copy of the survey findings. _____

THANK YOU FOR YOUR COOPERATION!

Please return to: NCIA, Room 1024, Dupont Circle Bldg.
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

NATIONAL STUDY OF JAIL SUICIDES

FACILITY CHARACTERISTICS

(The following will be used for internal purposes only.)

1) Name of facility: _____

2) Address (street): _____

(City, State, Zip Code): _____

(County): _____

3) Telephone: ( ) _____

4) In what year was your facility originally constructed? Date _____

5) What was the year of last renovation, if any? Date _____

6) What is the location of your facility?

(1) _____ Urban (2) _____ Suburban (3) _____ Rural

7) Which of the following categories best describes your facility? (Please check all that apply.)

(a) Facility for Committed/Sentenced Offenders _____
(b) Temporary Holding Facility for 0 to 4 Hours _____ or 4 to 48 Hours _____
(c) Pre-Trial Detention Facility (Over 48 Hours) _____
(d) Other (Please Specify) _____

8) How many suicides occurred in your facility in 1978 and 1980?

(1) _____ 1978 (2) _____ 1980

9) What procedures, if any, are utilized in dealing with inmates who exhibit suicidal tendencies? (If necessary, please attach additional sheets.)

_____

_____

_____

10) Are there any reporting requirements following a suicide? _____ If yes, explain these requirements and to whom reports are made. (If necessary, please attach additional sheets.) _____

_____

_____

Survey completed by (Name/Title): _____

_____

Date completed: _____

APPENDIX D - DISTRIBUTION OF ADDITIONAL CHARGES

SECOND CHARGE AGAINST VICTIM

	N	PERCENT
ALCOHOL/DRUG RELATED	22	6.5
SERIOUS PROPERTY	34	10.0
MINOR OTHER	29	8.6
VIOLENT PERSONAL	23	6.8
NONE	229	68.0
TOTAL	337	100.0

UNKNOWN=7

THIRD CHARGE AGAINST VICTIM

	N	PERCENT
ALCOHOL/DRUG RELATED	2	0.5
SERIOUS PROPERTY	9	2.7
MINOR OTHER	13	3.9
VIOLENT PERSONAL	8	2.4
NONE	304	90.5
TOTAL	336	100.0

UNKNOWN=8

FOURTH CHARGE AGAINST VICTIM

	N	PERCENT
ALCOHOL/DRUG RELATED	0	0.0
SERIOUS PROPERTY	1	0.3
MINOR OTHER	2	0.6
VIOLENT PERSONAL	1	0.3
NONE	333	98.8
TOTAL	337	100.0

UNKNOWN=7

APPENDIX E - DISTRIBUTION OF PRIOR CHARGES

FIRST PRIOR CHARGE AGAINST VICTIM

	N	PERCENTAGE
ALCOHOL/DRUG RELATED	51	20.0
SERIOUS PROPERTY	31	12.3
MINOR OTHER	35	13.9
VIOLENT PERSONAL	16	6.3
NONE	119	47.3
TOTAL	252	100.0

UNKNOWN=92

SECOND PRIOR CHARGE AGAINST VICTIM

	N	PERCENTAGE
ALCOHOL/DRUG RELATED	24	9.5
SERIOUS PROPERTY	28	11.1
MINOR OTHER	19	7.5
VIOLENT PERSONAL	6	2.4
NONE	175	69.5
TOTAL	252	100.0

UNKNOWN=92

THIRD PRIOR CHARGE AGAINST VICTIM

	N	PERCENTAGE
ALCOHOL/DRUG RELATED	11	4.4
SERIOUS PROPERTY	11	4.4
MINOR OTHER	17	6.7
VIOLENT PERSONAL	8	3.2
NONE	205	81.3
TOTAL	252	100.0

UNKNOWN=92

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